

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 22 August 2002

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In the Matter of :
 :
KENNETH L. ATKINS : Case No: 2000-BLA-348
Claimant :
 :
v. :
 :
WESTMORELAND COAL COMPANY :
Employer :
 :
and :
 :
DIRECTOR, OFFICE OF WORKERS' :
COMPENSATION PROGRAMS :
Party-in-Interest :
..... :

DECISION AND ORDER

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, 30 U.S.C. § 901 *et seq.* (the Act). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201.

On October 30, 2000, I issued a Decision and Order awarding benefits. I found that the instant duplicate claim¹ was filed on March 9, 1999; that the newly submitted evidence established complicated pneumoconiosis and thus a material change in condition pursuant to 20 C.F.R. § 725.309(d); and that due to the finding of complicated pneumoconiosis, the claimant was entitled to invocation of the

¹ In the prior claim, Administrative Law Judge Vivian Schreter-Murray ultimately found approximately thirty-eight years of coal mine employment, and simple pneumoconiosis arising out of coal mine employment pursuant to 20 C.F.R. §§ 718.202(a)(1), (4) and 718.203(b), but that total disability was not established. *Atkins v. Westmoreland Coal Co.*, 95-BLA-00764 (Sep. 10, 1996)(unpub.). That decision was affirmed by the Benefits Review Board. *Atkins v. Westmoreland Coal Co.*, BRB No. 97-0194 (Sep. 29, 1997)(unpub.).

§718.304 irrebutable presumption of total disability due to pneumoconiosis. Benefits were therefore awarded beginning March 1, 1999 with augmentation for one dependent. *Atkins v. Westmoreland Coal Company*, 2000-BLA-348 (Oct. 30, 2000)(unpub.).

The employer appealed that award to the Benefits Review Board. On January 18, 2002, the Board issued its Decision and Order affirming in part, vacating in part, and remanding the case for further consideration consistent with its opinion. The Board, Administrative Appeals Judge Regina C. McGranery dissenting, found the following errors in the decision awarding benefits: (1) the rationale for crediting Dr. Deponte's x-ray interpretation over the interpretations of other doctors allegedly was not adequately explained; (2) the decision to credit the findings of large opacities over contrary opinions allegedly was not adequately explained; and (3) I substituted my own opinion for that of physicians when I found irrelevant opinions of no complicated pneumoconiosis based upon a finding of no disabling respiratory impairment.

By Order dated April 15, 2002, I gave the parties thirty days to file comments as each deemed appropriate in light of the issues raised by the remand. (April 15, 2002 Order Granting Time to File Comments). Neither party filed comments.

Medical Evidence

The earliest x-ray in the record is that of March 28, 1983. It was read by a physician on behalf of the U.S. Department of Health & Human Services. He found Category 1 pneumoconiosis. The claimant was notified by the U.S. Dept. of Labor that due to that reading he had "enough pneumoconiosis to be eligible for the option to work in a low dust area of a mine."

The next x-ray was taken on March 19, 1986. Dr. James Castle read it as 1/0, r, 3 zones. Dr. Kirk Hippensteel read it as 1/1, r/q, 4 zones. Dr. Paul S. Wheeler read it as 0/1, q, 2 zones, and noted that "[t]his case is probably all healed [tuberculosis] because it is unilateral. Scattered calcified granulomata." Dr. William W. Scott, Jr., found "[f]ocus of nodules rt. upper lung compatible with Tb - unknown activity or histo. Doubt pneumoconiosis due to distribution." Dr. Bruce Stewart read the x-ray as 1/0, r/q, 4 zones. Although he rated the film quality as 1 (highest), he noted that "[p]oor inspiration accentuates lung markings."

An x-ray was then taken on January 5, 1994. Dr. S.K. Paranthaman rated it as quality 1 and found 1/1, q, 6 zones, ax (coalescence). Dr. Paranthaman also examined the claimant on that day and diagnosed coal workers' pneumoconiosis based on the x-ray reading. Dr. Paul Francke, Jr., rated the x-ray quality as 2 and found 1/1, u/q, 3 zones. However, Drs. Jerome F. Wiot, Ralph T.

Shipley, and Harold B. Spitz all found this x-ray unreadable for the presence or absence of pneumoconiosis.

The next x-ray was obtained on September 12, 1994 in relation to Dr. Abdul K. Dahhan's examination of the claimant. Dr. Dahhan read the x-ray as 1/1, and concluded there was radiological evidence of simple coal workers' pneumoconiosis, a finding he reiterated in his 1995 deposition. Dr. Wiot's reading of the September 12th x-ray was

no evidence of coal worker's pneumoconiosis. This patient shows calcified granulomata within the right second anterior interspace from old histoplasmosis or tuberculosis. In addition, there are a few "q" and "t" size opacities just above this area but the degree of profusion is not more than 0/1. 0/1 is a negative diagnosis for coal worker's pneumoconiosis and these are likely related to the granulomatous change described above.

Dr. Shipley found "[n]o pleural or parenchymal evidence of pneumoconiosis. Focal opacity in the right upper zone, likely the result of healed granulomatous disease. However, comparison with any previous or subsequent films is recommended to rule out an active process such as tuberculosis or lung cancer." Dr. Spitz stated "[n]o evidence of pneumoconiosis. Linear fibrotic strands in the right mid-lung field."

The x-ray of April 19, 1999 was read by Dr. Spitz as showing "[n]o evidence of coal worker's pneumoconiosis. The are (sic) of disease in the right upper lobe could be on the basis of previous granulomatous disease, but neoplasm cannot be excluded. Comparison should be make with old studies." Dr. Cristopher A. Meyer's reading of the same x-ray was "[n]o radiographic evidence of coal worker's pneumoconiosis. 2cm opacity in the right upper lung zone. This finding may be post-inflammatory, related to previous granulomatous disease, although neoplasm in this location is not excluded. Comparison with old films or chest CT scan is recommended for further evaluation." Dr. Young Kim found "[f]ocal irregular densities in the rt upper lobe, probably old granulomatous changes but without old films, possibility of lung nodule (cancer) cannot be excluded. Suggest CT evaluation for better details of lesion." Dr. Wheeler's reading was "2.5 cm mass lateral portion RUL or superior segment RLL with few linear scars extending laterally to chest wall and medially toward hilum compatible with granulomatous disease or possible cancer. Compare to old films or get CT scan to see if mass is calcified. No evidence of silicosis or CWP." Dr. Scott's reading was "[p]robable scar due to healed Tb RUL. However, cannot exclude cancer. Advise CT to further evaluate unless old radiographs are available documenting no change over several years." Dr. Peter J. Barrett read the x-ray as 1/1, q/p, 6 zones, large opacity A; rule out mass

RUL (ca). Dr. M. Ranavaya's reading was 1/0, p, 6 zones; large opacity A; rule out other pathology; CT scan recommended. Dr. Dominic Gaziano's reading was 0/0; lesion right apex, old scarring; need to rule out carcinoma. Dr. Manu Patel found "[p]/p opacities of 1/1 profusion affect all lung zones associated with a round mass, 2 cm in diameter, in the right upper lung zone, likely representing Category A large opacity of complicated pneumoconiosis, neoplasia not clearly excluded. Comparison with previous examination is crucial." Dr. Donald L. Rasmussen, who examined the claimant, obtained Dr. Patel's reading in regards to that examination. Dr. Rasmussen concluded that:

The patient has a significant history of exposure to coal mine dust with known x-ray evidence of pneumoconiosis since at least 1983. He now has evidence of complicated pneumoconiosis, Category A. Malignancy is somewhat unlikely in a lifelong non-smoker.

While this patient's coal mine dust exposure has produced no measurable loss of function, he does appear to have complicated coalworkers' pneumoconiosis. The patient and his personal physician were informed of the need for comparison of x-rays and close radiographic follow up.

The next x-ray was taken on May 3, 1999. Dr. Wheeler read it as showing "[a]ngular 3 m scar or mass in lower lateral portion RUL with few linear scars extending to lateral pleura and few adjacent small nodules and scars compatible with TB unknown activity, probably healed, but I can't r/o tumor. Compare to old films or get CT scan for better evaluation. ... No evidence of silicosis or CWP." Dr. Scott's reading was "[f]ocal scar, infiltrate, or mass lateral right upper lung. Tb or healed tb are likely possibilities. Cannot r/o cancer. Advise CT and comparison to old studies." Dr. Kim's reading was "[a] focal increased density or infiltrate in the rt upper lobe laterally suggestive of granulomatous process such as Tbc, unknown activity and cannot rule out small mass. Recommend CT." Dr. Wiot stated that "[t]here is no evidence of coal worker's pneumoconiosis. There is an area of infiltrate within the right upper lung field in the region of the first and second anterior interspaces laterally, which is not related to coal dust exposure. The etiology cannot be determined. This may represent a manifestation of an active inflammatory process, not excluding pulmonary tuberculosis and less likely malignancy. ... This patient should be referred to his private physician for further evaluation." Dr. Shipley found "[n]o pleural or parenchymal evidence of coal worker's pneumoconiosis. Right upper lobe opacity is of uncertain etiology. This may represent pneumonia. Comparison with prior or subsequent radiographs is recommended." Dr. Kathleen A. DePonte read the x-ray as 0/1, p/s, 6 zones; "2 x 1 cm opacity in rt upper lobe may represent complicated pneumoconiosis or scarring or carcinoma. Comparison

with old films is recommended."

Dr. DePonte then read a series of x-rays on May 18, 1999. She stated that "[t]he opacity at the right lung apex noted on the study of 05/03/99 was present on the previous examinations of 01/22/96 and 12/03/97. No significant change is appreciated. The stability of this abnormality is consistent with a benign process and likely represents a conglomerate mass of pneumoconiosis."

Dr. Emory H. Robinette, examined the claimant, obtained the x-ray of August 17, 1999. Dr. Richard Mullens, the first one to read it, found "[i]ll defined parenchymal densities in the right upper lobe of uncertain chronicity. This could represent chronic interstitial disease with parenchymal scarring, however, a acute infiltrate should also be considered. There are no previous films available for comparison." Dr. Robinette then read the x-ray as showing complicated coal workers' pneumoconiosis with a profusion abnormality of 2/2, predominant Q opacities with a Category A mass measuring 2.4 x 1.3 cm. Dr. Wheeler's subsequent reading was "[o]val mass or infiltrate in lateral portion RUL measuring approximately 4x2 cm and probable subtle nodular infiltrate in lower lateral right apex and lateral subapical portion RUL compatible with pneumonia or Tb but I can't r/o tumor/suggest CT scan. ... No evidence of silicosis or CWP." Dr. Scott's reading was "[m]inimal infiltrate and/or fibrosis RUL: consider Tb, pneumonia." Dr. Carl B. Binns stated that "[w]hile there are some small opacities present, the profusion level of 0/I is not diagnostic of occupational disease. There is a questionable infiltrate versus fibrosis or artefact seen overlying the right upper lobe region. Clinical correlation is recommended." He noted pneumonia as the questionable infiltrate. Dr. R.K. Gogineni found "[m]ild increased interstitial lung markings not conclusive of pneumoconiosis. There is, however, a parenchymal abnormality in the right upper lung. Although this may be related to infiltrate or scarring neoplastic process cannot be excluded. Clinical correlation advised. Follow up recommended." Dr. J. Baek's reading was "[n]onspecific interstitial changes which are inconclusive for the presence of occupational pneumoconiosis. Patchy increased density identified in the right upper lung zone. Short term follow up examination verses CT scan may be helpful."

The next x-ray was obtained on September 28, 1999 in relation to Dr. Dahhan's examination of the claimant. Dr. Dahhan read the x-ray as 0/0. In his conclusion, which took into consideration other medical records including his previous examination, he found "radiological findings equivocal for the diagnosis of simple coal workers' pneumoconiosis." Dr. Wheeler read the September 28th x-ray as showing a "2-2.5 cm irregular mass or infiltrate in lateral portion RUL between anterior ribs-2-3 with few adjacent linear scars and few tiny nodules or scars in lateral subapical portion RUL compatible with TB unknown activity. Suggest CT scan for better evaluation because this could also be cancer. ... No

evidence of silicosis or CWP." Dr. Scott's reading was "[i]nfiltrate peripheral right upper lung: probable Tb, possibly active." Dr. Wiot stated that "[t]here is no evidence of coal worker's pneumoconiosis. There are changes in the right first and second anterior interspaces consistent with a post-inflammatory process, possibly even an active inflammatory process, although this appears to be more the residual of previous changes." Dr. Kim's reading was "[f]ocal infiltrates in the rt upper lobe, probable Tb unknown activity."

Dr. Gregory J. Fino reviewed medical records including the x-ray readings by others. He did not read any of the x-rays himself. In his first report of April 28, 1995, he assumed simple coal workers' pneumoconiosis was present based on the divergent x-ray reading. However, Dr. Fino did not address whether a mass, or something like a mass, was present in the claimant's lung. He simply stated that complicated pneumoconiosis was not present because if it was, at least one of the following would be expected:

1. Changes on the chest x-ray suggesting distortion of the chest cavity, such as hilar retraction or subpleural emphysema.
2. Evidence of some abnormality on the lung function studies, either obstruction or restriction.
3. Reduced lung volumes.
4. A reduction in the diffusing capacity.
5. A drop in the pO₂ with exercise.

Dr. James R. Castle reviewed medical records and opined on May 2, 1995 that:

Radiographically there was some divergence of opinion between a number of B-readers. It was felt that one film was unreadable by a number of noted B-readers and this same film was felt to be minimally positive by two other individuals. The individuals that felt the film was positive for pneumoconiosis gave the quality of the film category 1 and category 2. Three of the noted B-readers felt that this film was unreadable. A second x-ray was noted by three noted B-readers to be entirely negative for pneumoconiosis, while one other B-reader, i.e. Dr. Dahhan, felt that the film showed minimal evidence of pneumoconiosis. Therefore, it would be my opinion after reviewing all the data, that the film was very likely negative for pneumoconiosis.

After another review in 2000, Dr. Castle stated that:

Once again, the radiographic evidence is somewhat variable in that several radiologists and B-readers have found evidence of simple coal workers' pneumoconiosis and a large opacity A in the right upper lung zone. The film that I personally reviewed did not show evidence of any parenchymal abnormalities consistent with pneumoconiosis. There was an infiltrate in the right upper lung zone, which in my opinion, did not represent a large opacity but was more consistent with an inflammatory process. Therefore, it is my opinion that the x-ray does not show radiographic evidence of complicated or simple coal workers' pneumoconiosis.

At his deposition on May 22, 2000, Dr. Wiot testified that:

[W]hen you look at an x-ray which you are trying to determine is a change from normal, what you are trying to do is find the earliest change that you possibly can. Since everybody is different, recognizing minor changes is much easier when you have a whole series of films on a patient than when you have a single film on an outpatient. And there is an adage which we teach the residents, and that is, "The answer is in the envelope." And that means that what you must do is you must look at all the old films in relation to the study that you are currently looking at, because what you are looking for is something which may be so minor that given on its own you may not necessarily recognize it. So any time that you have the opportunity, you read a series of x-rays rather than a single x-ray in order to make the determination whether it's normal or abnormal.

Dr. Wiot also testified that coal workers' pneumoconiosis "begins in the upper lung fields, more often on the right than on the left. If the disease process becomes more severe, it will progress down the lung, so it goes down the chest rather than up." As to complicated pneumoconiosis, he stated that "[t]hese are masses of fibrosis which occur more often in the upper lung fields, again, not infrequently symmetrical." On his review of the five x-rays from 1994 through 1999, he felt that the changes in the right upper lobe were probably old pulmonary tuberculosis.

Dr. Thomas M. Jarboe performed a medical record review on May 8, 2000. He stated that:

Within reasonable medical probability and/or certainty, I feel there is sufficient radiographic evidence to justify a diagnosis of coal worker's pneumoconiosis with respect to Mr. Atkins. There has been a wide range of interpretations of Mr. Atkins' chest x-rays. Early on, nearly all of them were read as positive for simple coal worker's pneumoconiosis. Even

now, some of the reviewers describe small nodules in the right upper lobe which they have ascribed to granulomatous disease but go on to read the x-ray as negative (0/0). It is my reasoned opinion that there is adequate radiographic evidence to make a diagnosis of simple coal worker's pneumoconiosis.

Much disputed is the question of whether or not Mr. Atkins has complicated pneumoconiosis. I do not feel that the evidence presented is adequate to allow a diagnosis of complicated pneumoconiosis. For example, Dr. Robinette read the x-ray of 8/30/99 as Category 2/2A. On the other hand, Dr. Mullens who was not reviewing this same x-ray for the presence of (sic) absence of pneumoconiosis only described ill-defined parenchymal densities in the right upper lobe. He does not describe a specific mass. Furthermore, regarding the x-ray of Dr. Wheeler describes a 2.5 cm. mass in the right upper lobe. However other observers describe it as an "infiltrate". (Drs. Scott and Kim). Thus I feel the radiographic evidence of complicated pneumoconiosis is not firm. Thus I am left to conclude that Mr. Atkins has evidence of simple and not complicated pneumoconiosis.

At his deposition on May 25, 2000, Dr. Dahhan testified that he reviewed three x-rays from 1994-99. He diagnosed simple coal workers' pneumoconiosis. He did not find any large opacity, not even a possible large granuloma. The abnormality he found was enlargement of the heart.

In his report of April 24, 1995, Dr. Shawn Chillag concluded that there was not sufficient evidence to justify diagnosis of CWP. He explained that:

There are two reports on an X-ray from January 5, 1994 that pneumoconiosis is present. Both of these were from B readers. There are three reports that these X-rays were unreadable by radiologists at the University of Cincinnati School of Medicine which was a participant in the development of the current international classification of occupational pneumoconiosis. There is one report from September 12, 1994 that pneumoconiosis is present. There are three reports from this same film that pneumoconiosis is not present with all of these being B readers. These are radiologists at the University of Cincinnati School of Medicine.

In his March 3, 2000 report, Dr. Chillag stated that:

I find it difficult to reconcile some of these reports without seeing the x-rays which would probably be very helpful. There are some particular areas that make

me believe that this is not simple coal worker's pneumoconiosis or that it is certainly not complicated pneumoconiosis. Dr. Dahhan changes his interpretation from a positive report to a negative report for simple coal worker's pneumoconiosis. This is not consistent with the natural history of simple coal worker's pneumoconiosis. The profusion is usually advanced in those individuals who have simple coal worker's pneumoconiosis and then develop complicated pneumoconiosis. This is not described by those who felt that simple and complicated pneumoconiosis were present. Additionally, there seems to be a rapid evolution of this right upper lobe lesion from a greater extent to a lesser extent that would be most consistent with an inflammatory lesion.

In his May 4, 2000 deposition, Dr. Wheeler testified that he read four x-rays, those of March 19, 1986, April 19, 1999, May 3, 1999, and September 28, 1999. He testified that the difference between the 1986 x-ray and those of 1999 was the development of the mass in the right upper lung. He stated that the mass was compatible with granulomatous disease or possibly cancer. Because the mass was stable, and surrounded by unilateral changes, he felt with a high degree of certainty that it was granulomatous disease", namely tuberculosis. Dr. Wheeler further testified that "I think it's very unlikely that this could be a pneumoconiosis of any sort. Bilaterality is one of the hallmarks of any pneumoconiosis." He also testified that "[i]t's granulomatous disease until proven otherwise."

As set forth in my previous Decision and Order the qualifications of the physicians are: **Aycoth**, B-reader; **Baek**, B-reader, board-certified radiologist (BCR); **Binns**, B-reader, BCR; **Burrett**, B-reader, BCR; **Cappiello**, B-reader, BCR; **Castle**, B-reader, board-certified pulmonologist (BCP); **DePonte**, B-reader, BCR; **Francke**, B-reader, BCR; **Gogineni**, B-reader, BCR; **Gaziano**, B-reader, BCP; **Hippensteel**, B-reader, BCP; **Kim**, B-reader, BCR; **Meyers**, B-reader, BCR; **Mullens**, none known; **Paranthaman**, B-reader; **Patel**, B-reader, BCR; **Ranavaya**, B-reader; **Robinette**, B-reader, BCP; **Scott**, B-reader, BCR; **Shipley**, B-reader, BCR; **Spitz**, B-reader, BCR; **Stewart**, B-reader, BCP; **Wheeler**, B-reader, BCR; and **Wiot**, B-reader, BCR.

Discussion

My review of the physicians's opinions indicates that there have been four disease processes cited as possible explanations for the changes in the claimant's right upper lung, described as either scarring, an infiltrate, or a mass, but a large abnormality nonetheless: (1) granuloma - possibly histoplasmosis, but most likely tuberculosis; (2) pneumonia; (3) cancer (neoplasm); or (4) complicated pneumoconiosis (large opacity A).

As to the possibility of tuberculosis, I found in my previous Decision and Order that:

[T]here [is not] any indication in the record that the Claimant has ever undergone tuberculosis tests or otherwise has a history of having tuberculosis. Although Dr. Wheeler seems certain that the abnormality is not complicated pneumoconiosis, he bases this on the fact that the opacity is only in the right upper lobe whereas complicated pneumoconiosis is always symmetrical. Dr. Wiot's testimony, however, indicates this is not necessarily the case although it often is.

I herein adopt that finding, but will address it further as instructed by the Board on this remand.

As to the possibility of pneumonia, I find that the evidence does not weigh in favor of such, as none of the examining physicians came to a diagnose of pneumonia. Further, the radiologists who performed serial x-ray reviews found the large abnormality to be consistently present, which appears to go against an acute inflammatory process or infiltrate, as none of them came to a conclusion of pneumonia or even possible pneumonia. Those serial x-ray reviews also concluded that cancer was unlikely, given the stability of the large abnormality.

The Board next remanded for consideration of issues relating to granulomatous disease/tuberculosis versus complicated pneumoconiosis.

(1) The Board found that I did not adequately explain my rationale for crediting Dr. DePonte's x-ray interpretation over the interpretations of other doctors. On re-review of the record, I again find Dr. DePonte's opinion entitled to greatest weight.

The evidence, cited and fully discussed in my prior decision in this matter, shows that a claimant's condition can best be diagnosed, absent a CT scan, by having a qualified radiologist compare a series of x-rays. Drs. DePonte, Wiot and Wheeler, all qualified as B-readers and board-certified radiologists, read a series of x-rays. They did not rely on other physicians' interpretations (which turned out to be confusing for some of the reviewing physicians), but looked at the x-rays themselves. Dr. DePonte's opinion weighs in the favor of complicated pneumoconiosis; Drs. Wiot's and Wheeler's in favor of old granulomatous disease or tuberculosis. However, of these three physicians, Dr. DePonte was the only one to review simultaneously the series of x-rays. I do not denigrate the intellectual prowess possessed by Drs. Wiot and Wheeler as evidenced by their impressive credentials in this record when I observe that their memories of Claimant's past x-rays is a less reliable basis for determining what a series of x-rays may reveal than Dr. DePonte's simultaneous review of the actual x-ray in the series. I therefore find Dr.

DePonte's opinion the more persuasive evidence in this regard.

(2) The Board found that I erred by not adequately explaining my decision to credit the findings of large opacities over contrary opinions. As I stated in my previous Decision and Order:

[O]ne thing is certain. There has been an abnormality in the right upper lobe of the Claimant's chest since at least March of 1986. There are Board certified radiologist and B-readers who have called this category A. There are others, whose qualifications also include faculty positions, who decline to identify the abnormality as complicated pneumoconiosis. They have indicated that it represents healed or active granulomatous disease, tuberculosis or possibly even cancer.

I correct that statement as the record shows that the earliest x-ray interpreted as showing an abnormality in the right upper lobe was the September 1994 x-ray, which Dr. Shipley read as showing a focal opacity. Dr. DePonte's report indicates that the opacity seen in 1999 was the same as that on the January 22, 1996 x-ray. The claimant ceased his coal mine employment in 1993.

While Dr. Dahhan concluded that there was no large abnormality at all in the claimant's right upper lung, he is the only physician who came to that opinion upon review of the claimant's post-1994 x-rays. I find his opinion outweighed by all of the other physicians who noticed that something was wrong with the claimant's right upper lung.

While the physicians differed in terminology, as discussed under (1) above, the record shows that the change is classifiable as a pneumoconiosis large opacity A. As indicated in Dr. Jarboe's report, whether changes were classified by a reader as consistent with simple and complicated pneumoconiosis depended on what process the reader felt was occurring in the lungs, not whether the changes could have been classified as consistent with pneumoconiosis. He indicated so much with his statement about readings of 0/0 despite findings of granulomatous disease nodules. Also, as apparent from Dr. Wheeler's deposition testimony, his overriding concern was that the changes he saw were not bilateral. Yet, the classification scheme allows the reader to indicate that the changes occur in only one to six of the lobes. When Dr. Wheeler read the March 19, 1986 x-ray, he read it as 0/1, q, 2 zones, even though he noted that he felt the changes were due to granulomatous disease.

Moreover, the regulations and the applicable classification system do not depend upon either an etiology assessment or bilateral opacities before a classification of complicated pneumoconiosis may be rendered. On balance then, the record establishes the presence of a large abnormality in the claimant's right upper lobe, which is classifiable as pneumoconiosis, large opacity, category A.

(3) The Board found that I substituted my own opinion for that of physicians when I found irrelevant opinions of no complicated pneumoconiosis based upon a finding of no disabling respiratory impairment. It is respectfully submitted that the Board misreads both the decision and the applicable regulation.

Section 718.304(a) specifically provides that when x-ray evidence reveals one or more opacities of 1 centimeter or more an "irrebuttable presumption" is invoked that the Claimant is totally disabled. As I pointed out in my previous Decision and Order, the Act and case law focuses on the size of the mass(es) seen either on x-ray or in tissue. This record does not contain any biopsy evidence. The x-rays, however, do reveal an opacity which satisfies the size requirement sufficient to support the existence of complicated pneumoconiosis within the meaning of §718.304(a). Although §718.304(c) would allow a claimant to establish complicated pneumoconiosis through other means in the absence of any x-ray or tissue evidence, nothing in § 718.304 requires a claimant to show that he has a pulmonary or respiratory impairment.

Consequently, when the irrebuttable presumption is invoked by x-ray, the Board fails to explain how it may be rebutted by medical opinion evidence that Claimant is not totally disabled. Under the applicable regulations, the question is not, as the Board alleges, a problem of an ALJ substituting his opinion for that of a physician, but rather it is the Board's willingness, contrary to Eastern Associated Coal Corp. v. Director, 220 F.3d 250, 258(4th Cir. 2000), to allow a physician to substitute his opinion for a regulatory classification system and a statutorily imposed irrebuttable presumption. Indeed, I recognized and found in my previous Decision and Order, that the evidence does not establish disability. The most the claimant appears to have is some mild obstruction.

Should the Board continue to hold to view that evidence relating to the degree of impairment is relevant to refute the x-ray classification system set forth in the regulations or to rebut the heretofore irrebuttable presumption established by x-ray under Section 718 304, further analytical guidance from the Board will be needed setting forth the factors the Board deems appropriate in accepting a medical opinion assessing the degree of disability as refutation of the regulations or rebuttal of what the regulations describe as an irrebuttable presumption.

For all of the foregoing reasons, a Decision and Order awarding benefits will again be entered.

ORDER

The Employer is ORDERED to pay benefits as set forth in the October 30, 2000 Decision and Order entered in this matter.

2002

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STUART A. LEVIN

Administrative Law Judge

Initially Signed: August 20,

(Failure of OALJ DMS Signature
application computer program
Required:)

2nd Signature: August 22, 2002

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2605, 200 Constitution Avenue, N.W., Washington, D.C. 20210.